Children's Choice Pediatrics

- 8112 Milliken Ave, Suite 201, Rancho Cucamonga CA 91737 P (909) 466-7337 F (909) 466-7338
- 510 N 13th Ave, Suite 2, Upland CA 91786 P (909) 931-1313 F (909) 920-3883

PATIENT INFORMATION / REGISTRATION New Patient ___ Change of Address/ Insurance ___ Date ____/____/_____

Patient / Child's Name:

Last _____ *First* _____ *M.I.* _____ *D.O.B* _____/_____/_____

*Gender M*____ *F*____ *SSN* _____-_____-_____ *Race* _____ *Ethnicity* _____ *Religion* _____

Patient's Address _____ *City* _____ *Zip* _____

Cellphone (_____) _____ *Home phone (_____)* _____ *Preferred Phone (_____)* _____

E-mail: _____ *Patient Portal Yes* ____ *No* ____

Preferred Language _____ *Hearing Impairment Yes* __ *No* __ *Submit Vaccines Records to CA vaccines registry? Yes*__ *No*__

PARENT/ GUARANTOR

Mother's Name *Last* _____ *First* _____ *D.O.B* _____ *SSN* _____-_____-_____

Home Address (same as patient___) _____ *City* _____ *Zip* _____

Cellphone (_____) _____ *Home phone (_____)* _____ *Work phone (_____)* _____

Occupation _____ *Work Address* _____ *City* _____ *Zip* _____

Father's Name *Last* _____ *First* _____ *D.O.B* _____ *SSN* _____-_____-_____

Home Address (same as patient___) _____ *City* _____ *Zip* _____

Cellphone (_____) _____ *Home phone (_____)* _____ *Work phone (_____)* _____

Occupation _____ *Work Address* _____ *City* _____ *Zip* _____

EMERGENCY CONTACT *(other than parents/legal guardian)*

Name _____ *Relationship to patient* _____

Address _____ *City* _____ *Zip* _____

Cellphone (_____) _____ *Home phone (_____)* _____ *Work phone (_____)* _____

PRIMARY INSURANCE: ***Primary Subscriber:*** *Mother* _____ *Father* _____ *Other* _____

Last _____ ***First*** _____ ***D.O.B*** _____ ***SSN*** _____-_____-_____

Health Plan _____ ***Insurance ID#*** _____ *Group#* _____

Address (same as patient___) _____ *City* _____ *Zip* _____

SECONDARY INSURANCE:

Last _____ *First* _____ *D.O.B* _____ *SSN* _____-_____-_____

Health Plan _____ *Insurance ID#* _____ *Group#* _____

Address (if different from patient) _____ *City* _____ *Zip* _____

Completed by _____ Mother/ Father/ Foster parent/ legal guardian/ other_____

Name: _____

DOB: _____

CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH THIS CHILD:

During which month of pregnancy did you first see the doctor?_____Month
How long was your pregnancy? _____Months

Where was baby born? _____
If baby was born at home, were blood tests for newborn screening done? ☐ Yes ☐ No

Did you have any illnesses or problems? (including sexually transmitted or other communicable diseases)	YES	NO	Did you use any non-prescribed drugs? (tobacco, alcohol, "street drugs:, over-the-counter or home remedies)	YES	NO
Did you take any medications prescribed by your doctor?	YES	NO	Did the baby go home with you from the hospital?	YES	NO
Did you have a difficulty/abnormal delivery/C-section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the 1st week of life?	YES	NO	Did baby receive any shots for Hepatitis B?	YES	NO

CHILD'S HISTORY: ☐ Male ☐ Female Is this child adopted? ☐ YES ☐ NO Birth Weight: _____pounds _____ounces Length: _____ inches

Has your child ever had (Please circle Yes or No):

Measles, Chickenpox, Mumps, Rubella	YES	NO	Vomiting after eating, refusal to eat	YES	NO
Tuberculosis or positive TB Test	YES	NO	Muscle, joint or bone problems	YES	NO
Tonsillitis/Sore Throat	YES	NO	Skin problems	YES	NO
Problems with eyes or vision	YES	NO	Headaches or dizziness	YES	NO
Problems with ears or hearing	YES	NO	Convulsions, seizures, epilepsy	YES	NO
Difficulty breathing/snoring at night	YES	NO	Diabetes	YES	NO
Heart problems	YES	NO	Thyroid problems	YES	NO
Asthma, bronchitis, or pneumonia	YES	NO	Allergies	YES	NO
Anemia, bleeding problems, blood transfusions	YES	NO	Problems with development of school performance	YES	NO
Stomachaches	YES	NO	Serious illness or accident	YES	NO
Diarrhea, Soiling self with stool	YES	NO	Surgery or hospitalization	YES	NO
Bladder Kidney Problems, Wetting self or bed	YES	NO	(GIRLS) Has she stared her periods?	YES	NO
Constipation	YES	NO	(GIRLS) Are there problems with her periods?	YES	NO

FAMILY HISTORY: Does mother (M), father (F), brother (B), sister (S), aunt (A), uncle (U), or grandparent (GP) have:

			Which Family Member?				Which Family Member?
YES	NO	Diabetes		YES	NO	High blood pressure	
YES	NO	Epilepsy or convulsions		YES	NO	Bleeding disorder	
YES	NO	Mental retardation		YES	NO	Tuberculosis	
YES	NO	Heart disease		YES	NO	Allergy	
YES	NO	Cancer		YES	NO	Lung or breathing problems	
YES	NO	Kidney or urinary disease		YES	NO	Eye disorder	
YES	NO	Bone or joint problems		YES	NO	Ear disorder	

PARENT INFORMATION:

	Mother:	Father:
Age:	_____	_____
Height:	_____	_____
Occupation:	_____	_____

HOUSEHOLD INFORMATION: Number of people in home _____
Are both parents living in the home? ☐ Yes ☐ No
Does anyone in the home smoke, or use drugs or alcohol? ☐ Yes ☐ No
Language spoken in the home: _____
Do you live in a: ☐ House ☐ Apartment ☐ Mobile Home ☐ Shelter ☐ Homeless

Patient Identification:

Signature: _____ Date: _____

Relationship to Child: _____

Reviewer's Signature: _____ Date: _____

Children's Choice Pediatrics

- 8112 Milliken Ave, Suite 201, Rancho Cucamonga CA 91737 P (909) 466-7337 F (909) 466-7338
- 510 N 13th Ave, Suite 2, Upland CA 91786 P (909) 931-1313 F (909) 920-3883

Today's Date: ____/____/_____

Patient's/Child's Name: _____ Date of Birth____/____/_____

Last *First*

AKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES (HIPAA):

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

☐ El padre o tutor del paciente menor de edad

☐ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____

Children's Choice Pediatrics

Parental Consent for Medical Treatment/ Assignment of caregiver

Date _____

Child's Information

Child's Name _____ Date of Birth _____

Address_____ City _____State _____ Zip_____

Caregiver's Information

1- Caregiver's Name_____ Phone Number _____

2- Caregiver's Name _____Phone Number _____

3- Caregiver's Name _____Phone Number _____

The above named caregiver is acting *in loco parentis* and shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, vaccines, diagnostic tests, physical exam, etc.), for the above named child, which may be required during my absence. This consent serves as permission for treatment at the offices of Children's Choice Pediatrics. Note: Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence.

This authorization shall be effective until (Date) _____ unless earlier revoked in writing to Children's Choice Pediatrics, by me.

Parent/Legal Guardian's Name_____ Phone Number _____

Signatures_____ Date _____

Children's Choice Pediatrics

- 8112 Milliken Ave, Suite 201, Rancho Cucamonga CA 91737 P (909) 466-7337 F (909) 466-7338
- 510 N 13th Ave, Suite 2, Upland CA 91786 P (909) 931-1313 F (909) 920-3883

Today's Date: _____/_____/_____

Patient's/Child's Name: _____ Date of Birth_____/_____/_____
Last First M.I.

CONSENT TO TREAT/ TREAT A MINOR/CHILD:

I, _____, the parent/legal guardian of the child/minor named in this document, give the permission to the health care provider to administer such examination, treatment, testing, vaccinations, medical plan and procedures as are deemed necessary in the course of the child/minor care.

AKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICE (HIPAA):
I understand and have been provided with a notice of privacy practices (privacy notice), which provides a more complete description of information and disclosures. I understand that I have a right to review the notice before signing it. I understand that I have the right to revoke this consent in writing, except to the extent that the healthcare provider has already taken action on my behalf.
I, the parent/legal guardian of the patient named in this document, have received a copy of this office's Notice of Privacy Practice.

SUBMISSSION OF VACCINES INFO TO CA IMMUNIZATION REGISTRY (CAIR)
I, the parent/legal guardian of this patient give permission to Children's Choice Pediatrics to submit vaccines records to CA Registry (CAIR).

FINANCIAL RESPONSIBILITY:
Information about me necessary to substantiate my insurance claims may be used by the healthcare provider involved in my care. I hereby authorize any insurance carrier with whom I have a policy to pay directly to the healthcare provider any benefits of any policies of insurances to the healthcare provider who has rendered the service to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the healthcare provider are not paid after reasonable notice, that account shall be deemed delinquent and a service charge fees shall be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for the collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amount in default.

OFFICE FINANCIAL POLICY:

- PAYMENTS/CO-PAYS: The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due and payable at the time of service. The patient/parent is expected to inform the office with any change of health plan/insurance or contact information at each visit.
- SELF-PAY ACCOUNTS: Self-pay accounts are patients covered by insurance plans in which the provider does not participate, patients without an insurance card on file, or patients who do not have any insurance coverage. The parents shall pay in full at the time of service.
- NON-PARTICIPATING INSURANCE PLANS: we will file to these insurance plans as a non-assigned claim as a courtesy to our patients. The parents shall pay in full at the time of service. The insurance company may or may not reimburse the parent on non-assigned claims.
- PATIENT REFUNDS: The following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims on the family's account, and there are no outstanding patient balances on the family's account.
- CHILD CUSTODY CASES: The custodial parent is responsible for co-payments at the time of service for participating instances and for all past due balances. If the non-custodial parent carries the insurance, the office will bill that insurance company. It is the parents' obligation to work out an agreement and insure payment to our office.
- AFTER HOURS: a fee may apply to any medical services rendered after hours including medical consult over the phone.
- CHECKS: we do NOT accept checks.
- FORMS FEE: a fee may be applied for School physical forms / sport physical forms / special letter/ vaccines records/ and medical records.

MISSING APPOINTMENT: *$25.00 fee may be applied for missed appointment, unless canceled or rescheduled 24 hours in advance.*
***Late to appointment**: if you are late more than 15 minutes to your appointment, the office may reschedule or cancel the appointment.*

By signing this document, I agree/ give permission on all items listed in this document.

Parent's Name _____ **Relation to patient** (Circle): Mother, Father, Foster parents, Legal guardian, Other _____

Signature_____

Witness (Name and Signature) _____ Title _____ Date _____